Patient Information Form

Patient Name (Last, First, MI)	Date of Birth: ___/___ /___	Social Security No.	Marital Status:	Today's Date ___/___ /___
Address:	Home Phone (_____) _____ - _____		Cell Phone (_____) _____ - _____	
City, State, Zip:				
Email Address:				
Employer Name:	Employer Address:	Employer City, State, Zip:	Work Phone (_____) _____ - _____	
Spouse's Name (Last, First, MI)	Date of Birth: ___/___ /___	Social Security No.	Spouse's Work Phone (_____) _____ - _____	
Other Emergency Contact:		Phone (_____) _____ - _____		
How would you prefer to be contacted for your appointments: Please circle which you prefer: **TEXT PHONE E-MAIL**				
How would you prefer to receive your balance billing: Please circle which you prefer: **TEXT MAIL E-MAIL** **Initial Here: _____**				

Insurance Information

Primary Insurance Name:	Address (Street/City/State/Zip)	Phone (_____) _____ - _____	
Name of Insured:	Relationship:	I.D. No.	Group No.
Secondary Insurance Name:	Address (Street/City/State/Zip)	Phone (_____) _____ - _____	
Name of Insured:	Relationship:	I.D. No.	Group No.

HEALTH HISTORY

Date of last physical exam_____

Has there been any change in your health within the past year? _____YES ____NO

Physician name and phone number_____

List any serious illness, operation, or hospitalization in the past 5 years?

_____

List all prescriptions/non-prescription medicine_____
_____

Do you require a **PREMED or antibiotic** before dental treatment (artificial joints or heart condition)
_____Artificial Joints YES_____ _____ _____NO

Do you take Bisphosphonates? _____YES _____ NO

Have you had head and neck radiation? _____YES _____ NO

CHECK ALL OF THE FOLLOWING DISEASES OR PROBLEMS YOU HAVE EXPERIENCED:

_____Allergies	_____ Hay fever	_____ Aids/HIV
_____Abnormal Bleeding	_____High Blood Pressure	
_____Asthma	_____Blood Transfusion	_____ Cancer
_____Depression/Anxiety	_____Diabetes	_____Epilepsy
_____Heart Valve or Pacemaker	_____Heart Murmur	_____Heart Attack
_____Rheumatic Fever	_____Kidney Problems	_____Liver problems
_____Sexually transmitted diseases	_____Thyroid problem	_____ Sinus Trouble

Are you ALLERGIC to or have had a reaction to:

_____Penicillin/Amoxicillin	_____Other Antibiotics / Please list_____	
_____Sulfa	_____Aspirin	_____Iodine
_____Codeine or other narcotics/Please List_____		
_____Local Anesthetics	_____Nuts/Peanut Butter	_____Latex

TOBACCO USE (Select all that apply)

_____Chew	_____Cigarettes/Cigar	_____Vape

WOMEN ONLY

Are you pregnant? ____YES _____NO How many weeks?_____

Are you using birth control? _____YES _____ NO

The answers I have given are true to the best of my knowledge. I am indicating my consent for necessary dental treatment by signing here:_____